MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL

SUBJECT: Laminectomy APPLIES TO: MHP☒ MLTCP☒ MSSP☒ HEALTHSELECT☒	Protocol #: PA P185.00 Protocol Pages: 1 Attachments: Yes☐ No☒ Initial Effective Date: June 1999 Latest Review Date: May 2002

MIHS HEALTH PLANS APPROVALS:

Director, Medical Management:_____Date:_____

Medical Director:_____Date:_____

Reviewed by Dr. Gary Lowery

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Laminectomy.

PROTOCOL:

A. Laminectomy
ICD9: 3.02
CPT: 63001 – Cervical
63017 - Lumbar
LOS: IP

B. The prior-authorization specialist may approve if the following are present:
1. Persistent and/or progressive signs of nerve root or spinal cord compression, such as motor weakness, sensory deficits –**OR**—

2. Pain and/or symptoms related to disc disease continues after 4 to 6 weeks of conservative medical treatment

AND

3. Radiologic evidence of nerve root compression compatible with the clinical findings

C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

E. If requirements are not met, Medical Director review is required.

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.